Chapter 1
Demographics

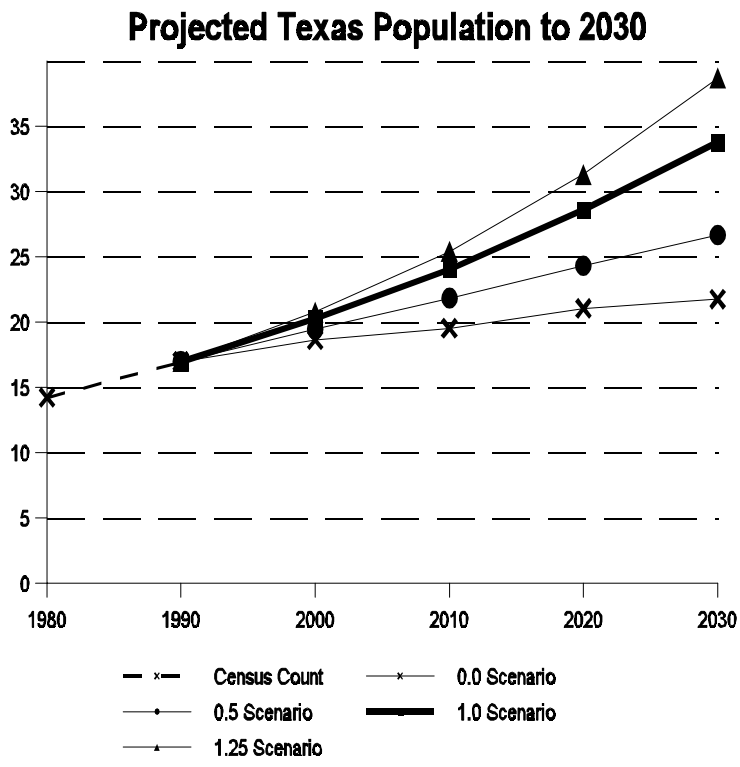
Texas is the second fastest growing state in the nation. In *Texas Challenged: The Implications of Population Change for Public Service Demand,* Murdock, et al., examine demographic changes and how they are expected to alter the demand for a variety of public and private sector goods and services. This section of the state health plan will look at the projected population growth in Texas. Special populations will be analyzed by projected growth, health trends, and barriers to accessing health care. The special populations discussed in this chapter are racial/ethnic groups, the elderly, uninsured Texans, and children – especially children in poverty. The projected rates of growth in these populations is dramatic and will result in significant increases in demand for health care services.[1] This increase in demand and the special health care needs of these populations must be taken into consideration in the planning and preparation of the Texas health workforce. This paper uses Murdock's population scenario 1.0, which assumes a continuation of 1980-1990 age, sex, and race/ethnicity-specific net migration rates. The 1.0 scenario is believed to be the most likely to characterize Texas' long-term future growth. This plan will also use Murdock's racial/ethnic designations of Anglo, Black, Hispanic and Other (Asian-Pacific Americans and Native Americans).

General Demographics

Currently about 19 million people live in Texas. Births, immigration, and in-migration from other states are the factors driving Texas' growth. There has been a steady growth trend in Texas since 1970, with the population increasing from 11.2 million in 1970 to 18.4 million in 1994. The Texas population is increasing at a rate roughly twice that of the nation as a whole and is second only to

California in population growth. This growth trend is likely to continue into the next century. Assuming a growth pattern similar to that which occurred in Texas between 1980 and 1990, the state's population will reach 33.8 million by the year 2030 (Figure 1-1).[2]

Figure 1-1



Source: Murdock, Steve, *The Texas Challenge*, 1997.

Texas' Racial/Ethnic Population Groups

Demographics

The above projected growth rate carries with it significant changes in the ethnic make-up of the state. Between 1990 and 2030, the Hispanic population is expected to increase by 250 percent, the Black population by 60 percent, and the category of Other by 648 percent from 360,000 in 1990 to 2.6 million in 2030. The Anglo population, however, is expected to increase by only 20 percent. Nearly 90 percent of the projected growth in the Texas population will be related to growth in the minority population groups. By 2030, minorities will make up 63 percent of the state's population with no one minority constituting a majority (Figure 1-2).[3]

Health Status of Racial/Ethnic Population Groups

Hispanics, Blacks, and Native Americans have a higher rate of illness and death in many preventable and treatable diseases. Examples of disparities in health status measures among minority populations include:

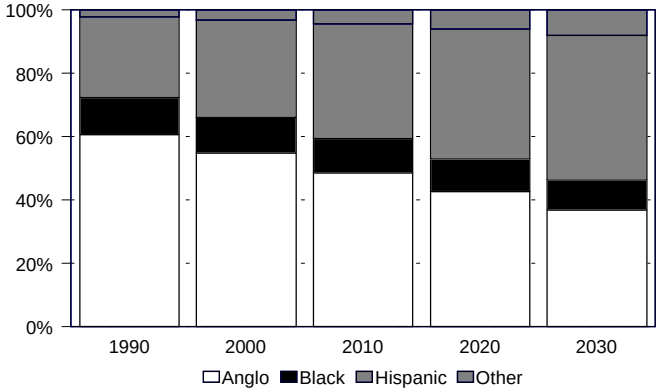
- The age-adjusted overall mortality rate shows that the death rate for Blacks in Texas is 32 percent higher than that of any other racial/ethnic group.[4]

- Morbidity and mortality from certain illnesses such as lung cancer, female breast cancer, cardiovascular diseases, AIDS, and tuberculosis indicate that minorities are disproportionately affected when compared to the overall population.[5]
- Despite dramatic decreases in infant mortality for the total Texas population, infant mortality rates in 1995 were almost twice as high for Blacks.[6]
- These disparities in health status among racial/ethnic minorities are reflected in other public health issues such as communicable diseases, births to adolescent mothers, and lack of first trimester prenatal care.[7]

Figure 1-2

Race/Ethnicity Distribution in Texas

1990-2030 / Using the 1.0 Scenario

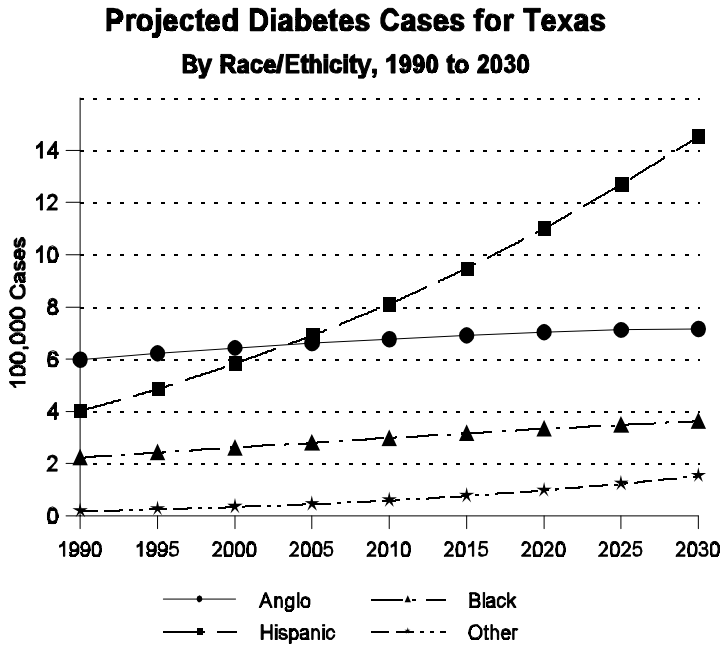


Source: Murdock, Steve, The Texas Challenge, 1997.

An analysis of one chronic disease, diabetes, serves as an example of the potential increase in demand for health services. The prevalence rate of diabetes in the Hispanic population is 9.3 percent and for Blacks it is 11.4 percent, while for Anglos it is 5.8 percent.[8] Given the same rates of incidence in these growing populations, the demand for health care dollars and services to treat diabetes and diabetes-related illnesses will increase dramatically over the next 30 years (Figure 1-3). (See Appendix A for complete information on Health Status Indicators for specific populations.)

Socioeconomic disparities attributable to level of educational attainment, occupational status, and income seem also to inversely affect the health status of minorities in the state.[9] Many special populations have a higher incidence of unemployment, poverty, violence, and higher needs for publicly funded health and human services programs. According to 1998 data, the unemployment rate for Blacks was 10.2 percent, 8.2 percent for Hispanics, and 4.3 percent for Anglos.[10]

Figure 1-3



Source: Texas Diabetes Council, Texas Department of Health, 1996.

Compared with other groups, greater proportions of Texas minorities live in poverty. In 1996, 30 percent of Hispanics, 23 percent of Blacks, and 8 percent of Anglos were below the poverty line (Figure 1-4).[11]

Smoking, alcohol abuse, poor dietary habits, and stress are highly correlated to adverse socioeconomic status and are among the most preventable risk factors associated with the leading causes of death for minorities.[12]

Access

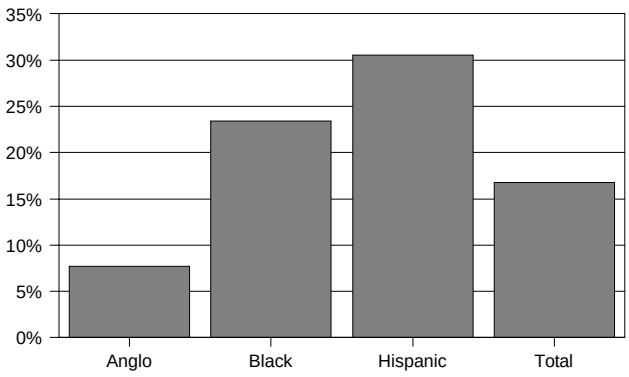
Minorities in Texas are more likely than Anglos to have difficulty accessing the health care system.[13] Those difficulties may be physical, financial, bureaucratic, or cultural. Physical barriers include geographical isolation and the concomitant lack of available services and transportation. These problems are most dramatic in rural areas, especially along the Texas/Mexico border in the *colonias*, and affect all rural residents.

In the financial arena, minorities are more likely to suffer economic hardship and are more likely to have inadequate or no insurance coverage. Almost 50 percent of uninsured Texans are Hispanic. Thirty-seven percent are Anglo or Other ethnic group, and 13 percent are Black (Figure 1-5).[14]

Bureaucratic barriers, which often include a limited knowledge of available services and the intricacies of confusing and varying eligibility standards, are further exacerbated by language and cultural barriers. The inability to fluently speak English can also prevent individuals from accessing health care services. After locating a provider, the individual must overcome obstacles in making

appointments, communicating medical needs, and understanding medication instructions. The number of non-English speaking people in Texas is expected to increase as the state continues to be one of the primary destinations for many immigrants, particularly from Mexico, Central America, and other Spanish-speaking areas.

Figure 1-4
Percent of Population Below Poverty
By Race/Ethnicity, Texas, 1996

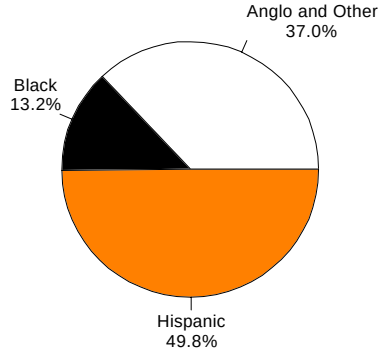


Source: Current Population Survey, Bureau of the Census. March 1997.

In addition to language differences, cultural distinctions between patient groups and medical providers can influence if and when an individual seeks medical services. If a health care system that seeks to treat the whole person and that is family and community oriented is to be implemented, it will require those who deliver care to have a basic understanding of how unique racial and ethnic cultural characteristics can affect lifestyle and health status. The frequency of use of professional services or facilities by a population is directly proportional to the level of cultural competency and the language skills of the workforce in that practice or facility.[15]

Minority representation among the practicing primary care physicians in the state is low. Of the 12,950 primary care physicians in 1998 in Texas, 67 percent were Anglo, 4 percent were Black, 13 percent were Hispanic and 14 percent were Asian-Pacific Islander.[16] Murdock states that, while it is not imperative that the racial/ethnic status of health personnel mirror that of the patient population, there will be increasing demand for the diversification of the health workforce in Texas. The broad ethnic diversity of Texas calls for a workforce that is, at best, an ethnic/cultural reflection of

Figure 1-5
Percent Uninsured by Race/Ethnicity
Texas, 1996



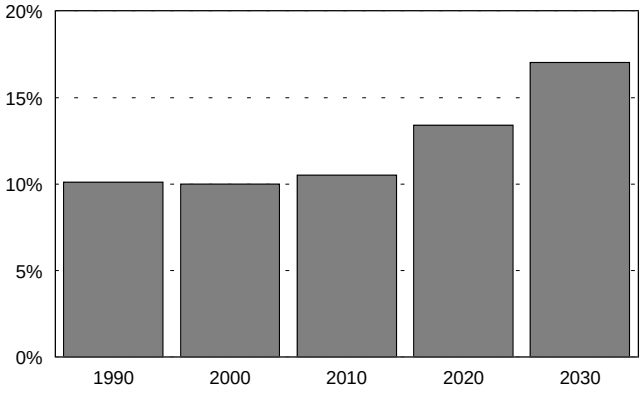
Source: Current Population Survey, U.S. Bureau of the Census, March 1997.

the population, and at least, well educated in the cultures, customs, and health beliefs of the major population segments it serves.[17]

Texas Elderly Population

The aging population in Texas, defined as those 65 years of age and older, constituted 10 percent of the population in 1990. By 2030, the number of individuals 65 and older is projected to reach 3.8 million, double the 1.9 million reported in 1996. At that time, they will constitute 17 percent of the state's population.[18] Figure 1-6 shows that the most significant increase in Texas' elderly population will occur between 2010 and 2020, when the baby boomers reach age 65 (Figure 1-6).

Figure 1-6
Population Projections, Age 65 and Older
as Percent of Total Population, Texas,1990-2030



Source: Murdock, Steve, The Texas Challenge, 1997.

The latest demographic data shows that in 1996, 74 percent of Texans over 65 were Anglo, 16 percent were Hispanic, and 8.5 percent were Black. Hispanics will make up the fastest-growing subgroup in the elderly population, and constitute 29 percent of Texas elderly by 2030. The numbers of other minorities (including Asians and Native Americans) in this age group are still rather small, but are expected to increase substantially in the first quarter of the 21st century (Figure 1-7).[19]

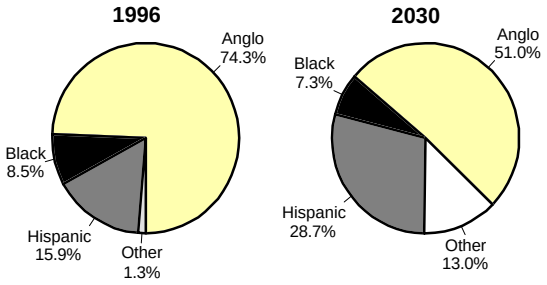
Health Status of the Elderly

Chronic diseases are a major cause of illness, disability and death in the United States. These conditions increase in number and severity as people age. The six leading causes of death for Texans over 65 in 1995 were cancer, heart disease, chronic obstructive pulmonary disease,

Figure 1-7

Texas Population, 65 and Over

By Race/Ethnicity in 1996 and 2030



Source: Texas State Data Center Population Estimates & Projection Program: Texas A&M University.

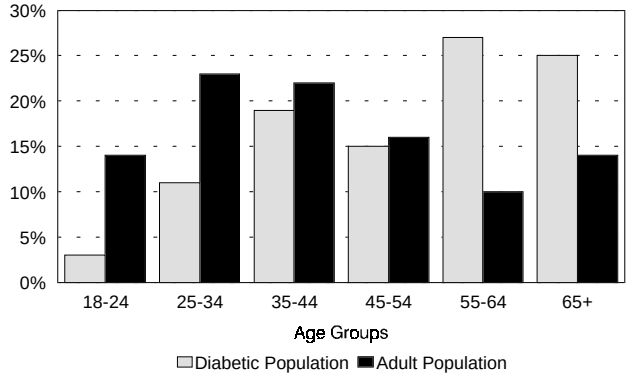
cerebrovascular disease, diabetes, pneumonia, and influenza. The first two causes, cancer and heart disease, accounted for 64 percent of all deaths for Texans from 65 to 74 years of age.[19] In the United States, chronic conditions account for two-thirds of the physician visits and hospital admissions and over 80 percent of prescription drug use.[20] By 2030 unless new systems are created, chronic care alone is projected to cost the United States $798 billion (in 1990 dollars) in direct medical and nursing home costs.[21]

Other conditions that threaten the health of the elderly include falls and hip fractures, lack of proper nutrition, Alzheimer's disease and depression. Murdock's study projects significant increases in the relative incidences of diseases of the male reproductive system, the endocrine system, the circulatory system, and diseases of the eye as the population of Texas ages. Thus in the years from 1990 to 2030 diseases of the male reproductive system will increase by nearly 200 percent (from 149,000 to 440,000 incidences), diseases of the circulatory system by 165 percent (from 5.9 million to 15 million incidences), and diseases of the endocrine system by 175 percent (from 1.3 million to 3.6 million incidences).[23]

Figure 1-8

Age Distribution of Diabetics in the Adult Population

Texas, 1995



Source: Texas Department of Health, Behavioral Risk Factor Surveillance System, 1995.

According to Murdock, "the aging of the population leads to faster rates of increase in the incidences of diseases and disorders in the future than the rates of population growth (Figure 1-8)." [24] These changes will "translate into changes in the number of patient days, physician contacts, and

cost of patient care, and in the level of demand for medical personnel."[25]

Access

Access issues for the elderly are primarily financial and physical. Fourteen percent of Texas' elderly have incomes below the poverty level and an additional 15.5 percent have incomes of no more than 25 percent above the poverty level. The socioeconomic difficulties of old age tend to be more pronounced in the minority elderly since they generally have lower-than-average financial resources. The minority elderly in Texas are more likely to have difficulties in accessing medical services, have less than adequate housing and/or no transportation, and have a greater tendency to manifest functional limitations in three or more instrumental and regular activities of daily living.[26]

A primary financial concern of the elderly is the cost of health care. The health care delivery system is expected to provide accessible and affordable services to the elderly when financing of that care is not within their means. However, increasing health care costs are making health insurance unaffordable to a growing number of elderly Texans.[27]

Health care for the elderly is financed by Medicare, private insurance, Medicaid and private pay. Medicare is a federal health insurance program for the elderly and certain persons with disabilities. The program is not free, and enrollment is not automatic. However, very few people over the age of 65 are denied entry into the program. Those who did not pay enough into Social Security while they worked may have to pay a program-determined monthly premium as well as deductibles that are assessed for certain medical services. Medicare does not cover all medical costs; therefore some people purchase supplementary insurance to cover the gaps in what Medicare does not pay. Medicare does not pay for preventive services nor does it pay for ongoing home care and nursing home services. Medicaid, however, does finance long term care services for eligible elderly. The eligibility criteria for this program are based mainly on low income and provisions for the blind, disabled, or aged. In 1994 Texas Medicaid spending for age 65 and over amounted to 27 percent of the total Medicaid expenditures.[28]

The physical availability of services for the elderly refers to the geographic location of services as

well as the special service needs of this population, including home health care and nursing home care. Geographically, 72 percent of elderly Texans live in metropolitan areas, while the remaining 28 percent live in rural areas.[29]

Approximately one in five elderly Americans needs help with common everyday activities such as bathing, dressing, grooming, and meal preparation. Home health care is the option of first choice, as most elderly with disabilities prefer to remain independent and stay in their own homes if at all possible. The aging population will substantially increase the need for home health, assisted living, and nursing home care in Texas. Murdock's data suggest that the number of nursing home residents and the costs of their care could increase by 233.1 percent from 1990 to 2030.[30]

In Texas, the health professionals with geriatric or gerontology certifications include physicians, advanced practice nurses, and physical therapists. Of Texas' 27,817 physicians delivering direct patient care in 1997, only 30 indicate a primary specialty in geriatrics while 60 indicate geriatrics as a secondary specialty. There are 139 advanced practice nurses with certifications in geriatrics and eight physical therapists. These numbers, compared with the projected growth of the aging population, suggest that there will be a growing need for health care practitioners who specialize in or are trained in geriatric needs and care.[31]

Children's Population

Demographics

In 1990 there were approximately 4.9 million children age 18 and under in Texas. They constituted 29 percent of the state's population. In 2030, they will represent 22.3 percent of the population, which will translate to 8.6 million children. [32] The defining feature of the children's population in Texas is the number of children living in poverty. The rate of poverty for children in Texas is higher than the national average. In 1995, 41 percent of the state's population living below the poverty level were children. Twenty-four percent of all Texas children, compared to 21 percent for the United States, were classified as living in poverty during that same period.[33] Statistics for 1997 show that the poverty rate for children in Texas has remained at the 24 percent rate.[34]

Murdock's population projections indicate significant growth in minority households and single-parent households. The percentage of households in poverty is projected to increase from 16 percent in 1990 to 19 percent in 2030. In this scenario,

> ...poverty would become more pervasive in Texas...(and) patterns of increased household poverty may be particularly problematic for households including children. Households with children would be especially impoverished by the demographic changes of the coming years, if the relationships between minority status and socioeconomic resources do not change.[35]

Health Status of Children

According to a national study conducted by the Agency for Health Care Policy and Research (AHCPR) in 1996, 80 percent of children in the United States were in excellent or very good health.[36] Even though the majority of children are in good health, the projected increase of the numbers of children in poverty in Texas should command our attention. Poverty increases a child's chances of poor health. Health conditions associated with poverty include low birth weight, higher blood lead levels, lower immunization rates, homicide, teen pregnancy, dental caries, and poor nutrition.[37] In addition, the AHCPR study found disparities in reported health status of Hispanic and Black children when compared to Anglo children. Eight percent of Hispanic children and four percent of Black children were perceived as being in fair/poor health as compared to 2.9 percent of Anglo children.[38] Poverty and lack of insurance coverage are two barriers for children's access to health care.

Access

The December 1996 report of the Texas House of Representatives Public Health Committee reported that 1.3 million children in Texas were uninsured. This number represents a quarter of all the children living in Texas and one-tenth of the children in the United States.[39] Lack of health insurance coverage is one of the greatest barriers to children accessing health care. The numbers of Texas' uninsured children is increasing. Between 1980 and 1990, employer coverage for dependents in Texas declined from 50 percent to 33 percent. One-fourth of uninsured children come from working families with annual incomes over $35,000 (Figures 1-9 and 1-10).[40]

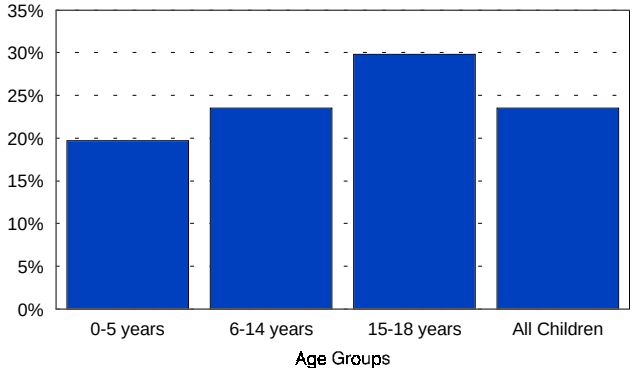
Lack of health insurance and the subsequent lack of proper medical care for children can have serious economic repercussions for Texas. The House Public Health Committee report states that:

> The high number of uninsured children affects employee recruitment and retention, worker productivity, the development of a skilled workforce, local property taxes, and the overall expense of health care services.[41]

Figure 1-9

Uninsured Children in Texas

By Age, 1996

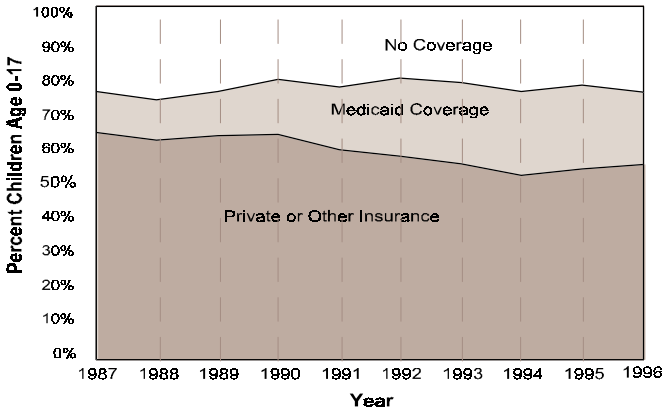


Source: Bureau of the Census and Texas State Data Center population estimates for 1996.

The Federal Balanced Budget Act (BBA) of 1997 provided for a child health insurance block grant under Title XXI of the Social Security Act. The BBA allocates $4 billion per year for the next 10 years to expand health care for uninsured children under 200% of poverty. States that elect to use these funds must designate them to Medicaid expansion, provision of other health insurance, or some combination of the two. States will have to match federal dollars in order to access the block grant. Texas' 1998 official allocation is $561.5 million, and the state would have to match that with $199.3 million to draw the grant funds.[42]

Figure 1-10

Children's Health Insurance Coverage, Texas, 1987 to 1996

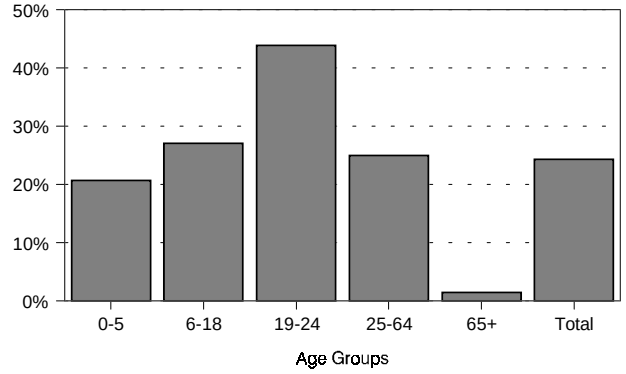


Source: U.S. Bureau of the Census, Current Population Survey, 1987 through 1996.
Note: Private or Other category includes all children with coverage by any non-Medicaid source.

The State of Texas is currently developing its Children's Health Insurance Plan (CHIP). The Texas Department of Health and the Health and Human Services Commission have proposed a two-phased approach. The first phase is to extend Medicaid coverage to children ages 15 to 19 at 100 percent

of federal poverty level. That phase was approved by the Health Care Financing Administration in July of 1998. Phase one matches the federal dollars with current state Medicaid dollars. Background and options for the second phase of the plan have been submitted to the Governor's Office for legislative examination.

Figure 1-11
Percentage Uninsured by Age Group
Texas, 1996



Source: Current Population Survey, U.S. Bureau of the Census. March 1997.

The creation of Texas Healthy Kids Corporation resulted from a 75th Legislative initiative to obtain medical coverage for the increasing number of children without health insurance. This is a public/private initiative to make affordable health insurance available to 1.3 million uninsured Texas children. The Texas Healthy Kids Corporation, a private, non-profit organization, will administer insurance coverage through private insurance providers including managed care organizations.

Factors Affecting Access to Medical Care due to the Growth of the General Population and Special Needs Populations

There are two main factors affecting the general population of Texas' access to medical care: insurance coverage and the geographic maldistribution of health professionals.

The lack of health insurance for the non-elderly population in Texas presents a significant problem for those needing access to health care. Twenty-four percent of Texans were uninsured in 1994-1995 (Figure 1-11), compared with 15 percent for the nation as a whole.[43] This high rate of uninsurance is attributed to low Medicaid coverage rates and the low number of people with employer-sponsored health insurance. Only 58 percent of the non-elderly in Texas are insured, compared with 66 percent for the nation as a whole. In 1994, Texas became the state with the greatest proportion of uninsured persons in the nation.[44]

The Council on Graduate Medical Education, which serves in an advisory capacity to the Department of Health and Human Services, the Senate Committee on Labor and Human Resources, and the House of Representatives Committee on Commerce, states in its 10th Report that:

> ....It is impossible to disentangle the issue of geographic maldistribution from that of health insurance. The most direct and efficient way to improve access to underserved populations is to assure they have health insurance coverage, and then address the residual problem of provider maldistribution with focused programs that deploy health professionals to places with insufficient providers.[45]

The geographic maldistribution of health care providers is an enduring feature of the American health care system. The discussion of maldistribution began in the 1930s, moved onto the public agenda in the 1960s, and culminated in a series of reports that led to a dramatic expansion in medical schools in the United States. By the 1980s it became apparent that there would soon be an oversupply of physicians, specifically in the specialty fields. This has led to what the 1998 Council on Graduate Medical Education report terms "the central paradox of the American health care system: shortages amid surplus."[46] This paradox is evident and aggravated in Texas with its large number of rural counties contrasted with large, populous metropolitan areas. Many rural counties in Texas experience serious shortages of physicians, nonphysician primary care providers, mental health workers, and allied health professionals.

At the federal level, interventions to mitigate provider shortages have included the deployment of health professionals to areas of need through:

- The National Health Service Corps.
- The establishment and funding of Community Health Centers and Rural Health Clinics.
- Support at the educational level to increase generalist specialties in family medicine, general internal medicine and general pediatrics.
- Economic incentives in the form of Medicare bonus payments and Health Professions Shortage Areas and Medically Underserved Area designations. [47]

State-level interventions include:

- Establishment of the Texas Health Service Corps.
- Incentive programs, such as the Medically Underserved Community State Matching

Incentive Program that helps underserved communities attract primary care physicians.

- Scholarship and loan-repayment programs, such as the Physician Education Loan Repayment Program, for physicians and nonphysician primary care providers who serve in Medically Underserved Areas or Health Professions Shortage Areas.
- Support at the educational level for programs such as the Family Practice Residency Program, including both rural and public health rotations, and other primary care residency programs.

Despite these efforts, shortages continue to exist.

This chapter has described the demographic changes projected to occur in Texas over the next 30 years. These changes will create an increased demand on health and human services that the state will be challenged to meet. Given those demographic changes, health trends and concerns, and access issues for the general as well as special populations, the central policy issues concerning the health workforce of the future are:

- Is the current and future supply of health care professionals in Texas adequate to meet the current and future needs of the population?
- Will the workforce have the necessary skills and knowledge to provide high-quality effective care?
- Will the workforce reflect and/or possess the competencies to meet the health care needs of a diverse population?

The next chapter will outline current health and health profession resources in the state.

Notes

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